COMMUNITY ENGAGEMENT & HEALTH EQUITY

In it Together—Building a Culture of Health

Annual Report & Project Summary · Project FY 7/2015 - 6/2016

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Community Engagement and Health Equity Annual Report

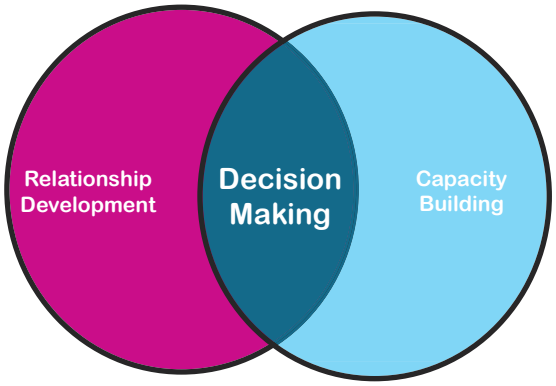
Village HeartBEART partners with American Heart Association and participates in National Walking Day 2016.

This fiscal year 2016, has been an amazing opportunity for us to serve and to combine both passion and compassion for community engagement, public health, and patient centered care to help those who were most vulnerable. We were able to solidify relationships with many new neighborhoods, faith-based organizations and numerous local, regional and national organizations to expand our reach to new opportunities for community engagement and inclusion. While MCHD is proud of its successes in keeping Mecklenburg County healthy, our strategic business plan acknowledges that the opportunity to be healthy is not equally available everywhere and for everyone in Mecklenburg County. Mecklenburg County continues to face many health inequalities that are rooted in poverty but it is also a county with a strong presence of committed civic and faith leaders, engaged community organizations and a viable County government with services that are beginning a stronger shift in the right direction to recognizing the value of "bringing services to the people."

Our county is splendidly diverse, and a movement toward better health, must reflect our individual beliefs, our family customs, and our community values. The word "health" has many meanings, so it can look very different to different people - and that's the way it should be. Addressing health disparities and health equity is both critical and challenging and will take shared accountability and the innovation of many. This report describes a summary of community engagement activities and accomplishments from July 1, 2015 to June 30, 2016 which aligns and document our efforts with (MCHD) Strategic Business Plan (Goal 3) to improve monitoring and increase access to resources and that address health disparities.

Community Engagement Framework:
The Community Engagement is administered and supported by 2 full-time positions. In order to make impact upon staff continues facilitate a variety of activities designed to link resources and citizens in need. This is accomplished at the individual level (arranging a referral for a citizen who walked into the Health Department trying to access a primary care physician) at the organizational level (facilitating and coordinating events, serving on board and committees, coordinating listening tours at the community, writing small grants to secure additional funding for services for an underserved group, etc.

There seems to be no simple or single answer to the question, "what is community engagement?" So, how do we decide? For now, our decision is based on community engagement is about (1) decision making, (2) relationship development, and/or (3) capacity building.



Community is a group of people who have common characteristics or shared identity; communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes or other similar common bonds. Ideally, there would be available assets and resources, as well as collective discussion, decision-making and action.

Capacity Building- Community Engagement Plan

- July 2016 staff member hired.
- August 2016, Data Subcommittee organized mainly to establish performance metrics for VHB.
- September 2016- Gramercy Research Firm –Technical Assistance- Co-Developed and Presented Framework and Deliverables for Community Engagement
- Village HeartBEAT- New Development of Framework for the Community Health Leadership Academy

Decision Making: OCE-HE Recommendations:

(submitted 9/15)

- Develop and implement a data-driven departmental community engagement plan
- Conduct an environmental scan (what are strengths of MCHD related to community engagement, what are weaknesses of MCHD or areas of attention needed around community engagement, What are opportunities community engagement present to MCHD, What are the risks or threats MCHD related to community engagement?)
- Partner with communities experiencing health equities and
- Align advisory committee structure, and processes to advance health equity.

The process for developing the Community Engagement Plan calls for activities to identify vision statements, strategies and actions to support MCHD efforts in its efforts to listen authentically to staff, partners with communities, in this way the meeting the intent of the MCHD Strategic Business Plan and the more detailed recommendation from the Advancing the Health Equity report. The process recommended multiple points

Community Engagement
The Center for Disease Control and Prevention (CDC) defines community engagement as the "process of working collaborative with groups of people who are affiliated by geographic proximity, special interests or similar situations with respect to issues affecting their well-being." (Box)

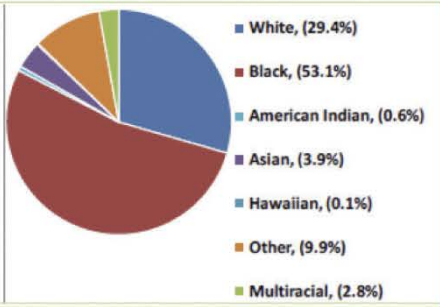
Relationship Building Village HeartBEAT

This program is designed to reduce the incidence of heart disease for traditionally underserved African-American and Hispanic neighborhoods within Mecklenburg County, North Carolina.

The acronym, "BEAT" describes the foundation of our strategies: Building (increasing the capacity of African American and Latino adults to address their own health needs while building the capacity of the faith community to initiate and sustain needed lifestyle changes); Education (increasing awareness and understanding of cardiovascular disease prevention, treatment and control); Accountability (accountability for success in every aspect of the program, including monitoring both individual and partner adherence to program objectives); and Together (collaboratively working to problem solve, with strong participant

Core Authentic Community Engagement Principles
- Inclusion and Demographic
- Collaboration and Shared Purpose
- Transparency and Trust
- Sustained Engagement and Participatory Culture

Qiana relayout to everything is filled before Monday

	PUBLIC HEALTH PRIORITY AREA (28205, 28206, 28208, 28212, 28216 and 28217
TOTAL POPULATION, 2013	**210,355**
Population Distribution By Race *(Hispanics are included in all Racial Categories)*	
Hispanic Population ,%	18.1%
Median Age	Range: 29 -32 yrs
Persons under 5 years, %	8.4%
Persons 65 years and over, %	9.1%
Population 25 yrs or older with less than High School Diploma, %	13.7%
Median Household Income	Range: $25,348 - $ 47,371
Unemployment Rates	Range: 10.3% - 23.6%
Total Deaths, 2012	**1,339**
2012 Leading Causes of Death	1 - Cancer 2 - Heart Disease 3 - Stroke 4 - Chronic Respiratory Disease (COPD)


Biometric screening for 2016 Competition Season

input in program design and execution).

The VHB intervention uses best evidence to trained community health workers to work with adults who have self-identified risk factors for cardiovascular disease. The program requires FBOs to commit to a 12-month program that includes a 16-week health and wellness challenge competition.

Components of the intervention include screening for baseline awareness, assessment of clinical measures and participation in smoking cessation classes. All participants are trained as ambassadors and are expected to conduct outreach efforts and implement local policy changes within congregations designed to increase access to health and wellness activities. Ambassador training occurs within the VHB Community Health Leadership Academy that leverages a train-the-trainer approach to implementation of the intervention while also building community capacity and creating sustainability. The VHB program has successfully position its approach for FY 2017 receiving recommendation from the County Manager to pilot small grants across faith-based organizations (N=5) to assist enrolled FBOs in recruiting new FBOs into the project. These grants will be provided through an in-kind contribution from MCHD in the amount of $60,000 that is dedicated to support outreach from the mentoring churches. Additional in-kind funding for this program will cover staff time and secure the on-going technical assistance of Gramercy Research.

This project has been designed specifically to ameliorate health disparities for disadvantaged populations residing in the PHPA – specifically traditionally underserved African-American and Hispanic populations. For these at-risk community members, churches may be the first point of contact and initial source of social support. Churches are well situated to connect with underserved populations and often are where vulnerable populations go to seek advice and build social networks. People that have a high-risk for development of chronic disease and live within under-resourced communities are less likely than others to seek health information on their own or from traditional health resources. Instead, they often rely on trusted community authorities within the FBO to make decisions about their own health behaviors. Indeed, an individual's social network has been shown to have a major impact on health behaviors; and, as a result, FBOs can be key partners in creating grass-roots level behavioral changes that can make a much broader impact on health behaviors and outcomes at a community-level.

The VHB pilot has successfully deployed evidence-based interventions into 20 African American faith-based organizations (churches) within the PHPA using a community-based participatory research approach. The VHB program has successfully recruited 270 participants and demonstrated compelling results with statistically significant changes seen in participant weight, BMI, systolic blood pressure, diastolic blood pressure, and hemoglobin A1c.

Evidence-based best practices that will lead to positive changes in health and health equity in the community.

The VHB program was build using best evidence for the intervention, the training program deployment, and program oversight. The Community Guide shows strong evidence for the success of social support/social networks in the community setting in increasing physical activity and there is a large body of literature showing faith based organizations as an effective community setting for addressing chronic disease prevention. The intervention employs the NHLBI cardiovascular disease prevention curriculum With Every Heartbeat is Life which focuses on identified risk factors: tobacco use, healthy eating and physical activity. The training program utilizes both the community health ambassadors' model which has shown promise in faith based behavioral change and the "train the trainer" model based on best evidence for development and deployment of community-based interventions. Implementation and oversight of the program will use key principles of community-based participatory research (CBPR) which also has increasing evidence supporting this approach as a best practice in community-based interventions.


Senior Chair Aerobics

2016 CHLA Graduates

Targeted Focal Areas- Framework: Community Health Leadership Academy (CHLA)

Cardiovascular Disease Reduction:
In fiscal year 2016, 270 minority adults were enrolled in the VHB program. Staff coordinated significant partnerships to focus clinical care, screenings, referral, health education, policy, system and environmental changes. Major risk factors include hypertension, obesity, smoking, high salt intake, stress, and sedentary lifestyle. VHB facilitates preventive screenings, nutritional, physical activities events, educational opportunities and medical referral and adherence to help eliminate risk factors.

- Enrolled 270 minority adults in VHB
- Recruited 21 Teams
- FBO Estimated Congregation Reach-20,000
- Provide 25 referrals
- Conducted 43 educational classes and reached
- Distributed 2,921 education materials

Diabetes
Diabetes Education Support Classes:
Coordinated partnership with the YMCA to refer VHB participants for self-management and education activities to manage diabetes. These activities are intended to equip individuals with the knowledge to make positive changes in their management of nutrition, exercise, and medication to improve blood-glucose control and reduce the risk of complications associated with diabetes. Classes are accredited by the American Association of Diabetes Educators (AADE). Participants commit to a 14 weeks of classroom instructions.
AHA- Power to Serve Program
AHA- Lifestyle Change Program
AHA- National Walk Day
NOVANT- Pre/ Post Screenings Events.
Tobacco Cessation Classes and Tobacco free/smoke-free FBO campuses, educated leaders on electronic cigarette.
Healthy Cooking Demonstration- Johnston and Wales
Weekly Walking Teams and Chair Aerobic
Zumba Classes
Fitness on the Dance Floor
Water Aerobics
Family Hearts of Champion Field Day
MLK Parade
Annual Greenway 5 K
HIV/AIDS

Actively coordinated with Community Health to facilitated the following activities:

Million Heart Initiative:
MCHD committed to partnering with Region IV US Office of Secretary-DDHHS. Through this partnership, MCHD will recruit churches for the 100 Million Heart Congregations. As a partner, MCHD supports the overall health reform strategy aims to expand access and education to high-quality healthcare to ethnic and racial populations in pilot jurisdictions. MCHD will the coordination efforts for fun challenge against Mississippi to reach the 100 congregations.

Health Disparities/Health Equity Driven Presentations,
Staff presented at numerous events. Request came from sources including: Elected official, higher education institutions, health professional associations, non-profit groups, private sector health care providers, local government and advocate groups.
HIV Retreat
BTAN Partnership and Information Sharing and Training Sessions
Preliminary Strategy Session: HIV Mapping of Educational/Testing Outreach
Facilitated 2 sessions for HIV Consumers
Published 3 Community Engagement Matters Newsletters
Served on the Annual Beverley Earle Minority Health Symposium providing health disparities expertise in implementing community engagement strategies with priority populations

Provided recommendations for the QI Team for the cultural competency training modules
Sponsored and coordinated 2 pastors' roundtables; including County Manager engagement with Pastors (February and April)
Co-coordinated with county manager's office first town hall or seniors
Served on county's grant review committee (Prevention and Wellness) Outside Agency grants
Served on the Chamber panel on health disparities (June 20)

Impact on Population Health and Health Equity in the Target Community.

The intervention focuses on high-risk region within Mecklenburg county designated as a Public Health Priority Area (PHPA) with 210,000 residents (see Figure 1, below). The PHPA communities have a high proportion African Americans (53%) and Hispanics (18%) that will be targeted for this intervent8ion. The community has increasing rates of cardiovascular disease (8%), hypertension (29%), and high cholesterol (33%) with heart disease being a leading cause of mortality. Engagement in unhealthy lifestyle behaviors is also increasing with overweight/obesity now impacting 57% of the population while consumption of 5+ fruits/vegetables daily has decreased to 18% and lack of physical activity within the past month remaining at 18%.

Fiscal Year 2016 Milestones include:

FBO partners are addressing population health and health equity by: (i) expanding the VHB model to create formal partnership agreements between government agencies and FBOs to increase the participatory nature of this intervention; (ii) using the VHB model to connect participant Ambassadors to community-based social services providers.

VHB-Hearts of Champion 16-week challenge yield the following preliminary results: 286 names on the list; 270 people completed both pre and post baseline measures collected.

- Average weight at the beginning was 209.3 + 50.8 lbs. (range 113 - 506)
- Average weight after 16 weeks was 205.6 + 50.2 lbs. (range 112 - 491 lbs.)
- Average weight loss was -3.4 + 9.1 lbs. (range -63.6 lost to 18 lbs. gained)
- Average weight change was -2% + 4% (range -24% lost to 10% gained)
- Average systolic blood pressure went down 4.6 mmHg and average diastolic blood pressure went down 1.9 mmHg. This is the equivalent of one blood pressure medication!!!

Relationship Building

(Key Partners)

The VHB program has established a network of key partners that has led to its expansion, ensured the project's successful implementation, maintained high levels of community involvement, and promoted subsequent dissemination and sustainability efforts.

Faith-based organizations (FBOs) participated in VHB trainings and competition activities, recruit Health Ambassadors for trainings, form VHB competition teams, and recruited participants. FBOs are working closely

2016 Family Field Day

to collaborate with the MCHD and the advisory board to develop policies addressing health-related behaviors (e.g., tobacco use, food choices, physical activity opportunities).

Novant Health's "Remarkable You" initiative has assisted targeted and intentional community-based behavioral health screening and coordinated care for the management of cardiovascular risk factors. **The American Heart Association** also provides ongoing technical support, and the **YMCA and Park and Recreation** facilitate the use of facilities for team, program and community health-related activities. Third, key partners supported the evaluation of this program including MAPPR team and Gramercy Research who both bring expertise in the collection and analysis of qualitative and quantitative data as well as community based participatory research approaches.

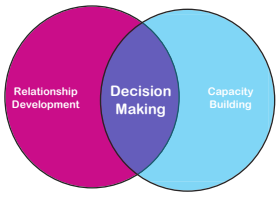
Ms. Thereasea Clark Elder, BSN, RN
2016 Hearts of Champions Gala

Pastor's Round Table Discussion

2016 MLK Parade

FY16: Milestones

Strategic Direction: Developments of Population-based Interventions



Key Initiative #1: Development of Population-based Interventions
Description: Identify key partnership strategies and prioritize Health Department-led interventions to impact policy, systems and environmental change to promote health and prevent disease.
Rationale: An essential service of public health is to develop polices and plans that promote community-wide health improvement.
Smart Goals • By June 2016, create a data-informed health disparity strategy that builds MCHD capacity to advance health equity • By June 2016, 95% of the VHB participants will improve in at least one health outcome • By June 2016, expand VHB, a population-based intervention leveraging external partners
Updates/Project Milestones: Created a data-informed health disparity strategy that builds MCHD capacity **1 additional Staff Hired** **Established Cross-sector collaborations –** Staff facilitated, implemented, presented and/or attended over 115 community-based/educational classes/ community listening tours events. Request came from sources

Established joint-collaborative planning and program deliverables at the community level for department and other human service departments for collaboration: (i.e. DSS listening tours, Office of Policy and Prevention-training on tobacco policy and smoking cessations).

- **Examples of Selected Programs Deliverables**
- BTAN Partnership and Information Sharing and Training Sessions
- Preliminary Strategy Session: HIV Mapping of Educational/Testing Outreach
- Facilitated 2 sessions for HIV Consumers
- Published 3 Community Engagement Matters Newsletters
- Served on the Annual Beverley Earle Minority Health Symposium providing health disparities expertise in implementing community engagement strategies with priority populations
- Provided recommendations for the QI Team for the cultural competency training modules
- Sponsored weekly senior CVD prevention educational activities
- Sponsored and coordinated 2 pastors' roundtables; including County Manager engagement with Pastors (February and April)
- Co-coordinated with county manager's office first town hall or seniors
- Served on county's grant review committee (Prevention and Wellness) Outside Agency grants
- Presented on panel on Chamber's Healthy Charlotte- topic: health equity/health disparities
- Attended and Presented at 45 community-based neighbor events
- Distributed 2,921 education materials

VHB participants will improve in at least one health outcome

- Recruited 21 Teams
- 4 Focus Groups Conducted
- Enrolled 270 minority adults
- Trained 49 Community Health Ambassadors
- FBO Estimated Congregation Reach-20,000
- Provide 25 referrals

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Expand VHB, a population-based intervention leveraging external partners

New Additional Cross-Sectional Partnerships Identified

The VHB program has established a network of key partners and new cross-sectional partners that has led to its expansion, ensured the project's successful implementation, maintained high levels of community involvement, and promoted subsequent dissemination and sustainability efforts.

Million Heart Initiative: Region IV US Office of Secretary- DDHHS. Through this partnership, MCHD will recruit churches for the 100 Million Heart Congregations. As a partner, MCHD supports the overall health reform strategy aims to expand access and education to high-quality healthcare to ethnic and racial populations in pilot jurisdictions. MCHD will the coordination efforts for fun challenge against Mississippi to reach the 100 congregations.

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Awards/Recognition

Community Outreach Champion- VHB Million Hearts Initiative, Regional IV, US HHS

Conference Presentations

APHA

Maya Angelou Center for Health Equity

UNCC- 2nd Annual NC State Rep. Beverly Earle Minority Health Conference

NACCHO

Featured - Pride March 2016 Women Issue- Featured Among the Top "Leading African American Women" in Mecklenburg